Kenneth J. Kelly (KK-4195)
Jennifer M. Horowitz (JH-3173)
Epstein Becker & Green, P.C.
250 Park Avenue
New York, New York 10177
212-351-4500
Attorneys for Defendant
Aetna Life Insurance Company

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

FREDRIC JOEL COHEN, M.D., P.C.
(Tatyana Zeldin)

Plaintiff,

– against –

AETNA U.S. HEALTHCARE INSURANCE COMPANY,

Defendant.

---

06 CV 15187

Civ. _____

NOTICE OF REMOVAL

TO THE HONORABLE JUDGES OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK:

Defendant Aetna Life Insurance Company ("Aetna"), named incorrectly by plaintiff as "Aetna U.S. Healthcare Insurance Company," by its attorneys Epstein Becker & Green, P.C., respectfully seeks to remove this action from the Civil Court of the City of New York, County of New York, to the United States District Court for the Southern District of New York. As reasons therefor, Aetna states as follows:

THE CIVIL COURT ACTION

1. Plaintiff Fredric Joel Cohen, M.D., P.C. purported to institute an action against Aetna in the Civil Court of the City of New York, County of New York (the "Civil Court Action") by serving a summons and endorsed complaint by regular mail to Aetna's New York

office, 99 Park Avenue, New York, New York. A copy of the summons and endorsed complaint ("complaint") is attached as Exhibit A.

2. Upon information and belief, plaintiff has offices located at 61 East 66th Street, New York, New York 10021.

3. As set forth more fully below, plaintiff's complaint seeks recovery of the sum of $57,243.00, plus interest, for services rendered to the beneficiary of a health plan with Automatic Data Processing, Inc. ("ADP"). Aetna and ADP entered into a contract pursuant to which Aetna provides administrative services to ADP in connection with ADP's self-insured health benefits plan.

4. The Civil Court Action is removable from the Civil Court to this Court pursuant to 28 U.S.C. § 1441(a), because the complaint raises claims under the laws of the United States over which this Court has original jurisdiction under 28 U.S.C. §1331.

BASIS FOR REMOVAL

5. Plaintiff alleges that Aetna issued health insurance to Tatyana Zeldin. Upon information and belief, Ms. Zeldin received health insurance from her employer, ADP. The plan of health benefits provided by ADP to its employees, including Ms. Zeldin, constitutes an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act ("ERISA") 29 U.S.C. §§ 1001, et seq.

6. Aetna provides administrative services to ADP in connection with ADP's health benefits plan pursuant to an administrative services contract between Aetna and ADP.

7. Plaintiff has asserted one cause of action against Aetna in the complaint, alleging that Aetna breached an insurance contract when it refused to pay health coverage claims arising from Ms. Zeldin's insurance provided by ADP.

8. Because plaintiff's claim against Aetna relates to an employee benefit plan within the meaning of ERISA, Aetna may remove to this Court pursuant to 28 U.S.C. § 1441(a).

9. ERISA provides an exclusive federal enforcement scheme for claims by plan beneficiaries and preempts state tort and contract actions. 29 U.S.C. §§ 1132 and 1144.

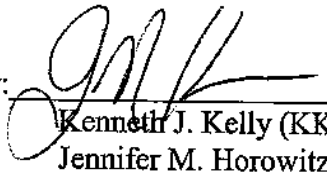
10. This notice has been filed within the time provided by 28 U.S.C. § 1446(b) and the Federal Rules of Civil Procedure. Aetna received the summons and complaint on December 7, 2006.

11. Upon the filing of this notice, Aetna will give written notice to plaintiff's attorney and will file a copy of this notice with the Clerk of the Court, New York City Civil Court, County of New York.

WHEREFORE, Aetna Life Insurance Company requests that the Civil Court Action now pending in the Civil Court of the City of New York, County of New York, be removed to this Court.

New York, New York
December 14, 2006

EPSTEIN BECKER & GREEN, P.C.

By: 

Kenneth J. Kelly (KK-4195)
Jennifer M. Horowitz (JH-3173)
250 Park Avenue
New York, New York 10177-0077
(212) 351-4500
Attorneys for Defendant
Aetna Life Insurance Company

Exhibit A

CIVIL COURT OF THE CITY OF NEW YORK
COUNTY OF NEW YORK

Index No. 070293CV2006

FREDRIC JOEL COHEN, M.D., P.C.
(Tatyana Zeldin)

plaintiff,

-against-

AETNA U.S. HEALTHCARE INSURANCE COMPANY,

defendant.

X

SUMMONS

Plaintiff's Address
61 East 66th Street
New York, New York 10021
The basis of the venue designated is:
Plaintiff's place of business.

To the above named defendant:

You are hereby summoned to appear in the Civil Court of the City of New York, County of New York at the office of the said Court at 111 Centre Street, in the County of New York, City and State of New York, within the time provided by law as noted below and to file your answer to the endorsed summons with the Clerk: upon your failure to answer judgment will be taken against you for the sum of $ 57,243.00 with interest thereon from the 12th day of April, 2005 together with the costs of this action.

Dated: October 27, 2006

Robert A. Santucci
Attorneys for Plaintiffs:
SANTUCCI & ASSOCIATES
67 Wall Street – 22nd Floor
New York, New York 10005-3111
(212) 709-8357

Defendant's Address:
Aetna U.S. Healthcare Ins. Co.
99 Park Avenue
New York, New York 10016

Note. The law provides that: (a) If this summons is served by its delivery to you personally within the City of New York, you must appear and answer within TWENTY days after such service; or (b) If this summons is served by delivery to any other than you personally, or is served outside the City of New York, or by publication, or by any means other than personal delivery to you within the City Of New York, you are allowed THIRTY days after proof of service thereof is filed with the Clerk of this Court within which to appear and answer.
"If the cause of action is for money only and a formal complaint is not attached to the summons, strike the words "annexed complaint." If a formal complaint *is* attached to the summons, strike the words "endorsed summons."

ENDORSED COMPLAINT

A statement of the nature and substance of the plaintiff's cause of action is follows:

Jurisdiction and Venue: Plaintiff is a professional corporation with a place of business in the County, City and State of New York. Upon information and belief, defendant is a domestic corporation with a place of business at 99 Park Avenue, New York, New York 10016 and who transacts business within the City and State of New York. This transaction arose in the County, City, and State of New York.

First Cause of Action: This is an action for breach of contract. Heretofore defendant or its agent issued to Tatyana Zeldin medical insurance coverage. That on or about or between March 12, 2005 and April 12, 2005 plaintiff provided medical services to Tatyana Zeldin and submitted medical claims to the defendant in the amount of $ 57,242.00 which the defendant refused to pay.

Attorneys for Plaintiff:
SANTUCCI & ASSOCIATES
67 Wall Street
22nd Floor
New York, New York 10005-3111
(212) 709-8357

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)		
							W056572960		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE (MM DD YY)	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
ZELDIN TATYANA			10/24/1961	M [ ] F [X]			ZELDIN TATYANA		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
49 COMMODORE DR			Self [X] Spouse [ ] Child [ ] Other [ ]				49 COMMODORE DR		
CITY		STATE	8. PATIENT STATUS				CITY		STATE
STATEN ISLAND		NY	Single [ ] Married [X] Other [ ]				STATEN ISLAND		NY
ZIP CODE	TELEPHONE (INCLUDE AREA CODE)		Employed [X] Full-Time Student [ ] Part-Time Student [ ]				ZIP CODE	TELEPHONE (INCLUDE AREA CODE)	
10309	(718)227-6261						10309	(718)227-6261	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
							800201-10-100		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS)				a. INSURED'S DATE OF BIRTH (MM DD YY)	SEX	
			YES [ ] NO [X]				10/24/1961	M [ ] F [X]	
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY)	SEX		b. AUTO ACCIDENT?	PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME		
	M [ ] F [ ]		YES [ ] NO [X]				AUTOMATIC DATA PROCESSING INC.		
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES [ ] NO [X]				AETNA		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
							YES [ ] NO [X] If yes, return to and complete item 9 a-d.		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM DD YY)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ]	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 478.1 2. 470 3. 478.0 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
		23. PRIOR AUTHORIZATION NUMBER 36399081-0000-0000	

24. A DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03/25/2005	03/25/2005	11	S	99070			2500.00					

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
112-49-5859	[X]	ALPHA	[X] YES [ ] NO	$ 2500.00	$ 0.00	$ 2500.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED Fredric Cohen DATE 11/15/05	FREDRIC COHEN MD 61 EAST 66 ST NEW YORK NY 10021	FREDRIC COHEN MD (212) 452-0077 61 EAST 66 ST NEW YORK NY 10021
	PIN#	PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION — PATIENT AND INSURED INFORMATION — CARRIER

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM HCFA-1500. APPROVED OMB-1215-0065 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): W056879980

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ZELDIN TATYANA

3. PATIENT'S BIRTH DATE: 10/24/1961 SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ZELDIN TATYANA

5. PATIENT'S ADDRESS (No., Street): 49 COMMODORE DR

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 48 COMMODORE DR

CITY: STATEN ISLAND STATE: NY

8. PATIENT STATUS: Single ☐ Married ☒ Other ☐ Employed ☒ Full-Time Student ☐ Part-Time Student ☐

CITY: STATEN ISLAND STATE: NY

ZIP CODE: 10309 TELEPHONE (Include Area Code): (718)277-9261

ZIP CODE: 10309 TELEPHONE (INCLUDE AREA CODE): (718)277-9261

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 800201-10-100

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

b. INSURED'S DATE OF BIRTH: 10/24/1961 SEX: M ☐ F ☒

b. OTHER INSURED'S DATE OF BIRTH: SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

c. EMPLOYER'S NAME OR SCHOOL NAME: AUTOMATIC DATA PROCESSING INC.

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

d. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 478.1
2. 478.0
3. 470
4.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 38398081-0000-0000

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03/25/2005	03/25/2005	11	S	30620	50	478.1	10000.00					
2 03/25/2005	03/25/2005	11	S	30520		470	10000.00					
3 03/25/2005	03/25/2005	11	S	30140	50	478.0	10000.00					
4 03/25/2005	03/25/2005	11	S	31200			5000.00					
5 03/25/2005	03/25/2005	11	S	14061			5000.00					
6 03/25/2005	03/25/2005	11	S	30220	50		5000.00					

25. FEDERAL TAX I.D. NUMBER: 112-49-5859 SSN EIN ☒

26. PATIENT'S ACCOUNT NO.: ALPHA

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 45000.00

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ 45000.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Fredric Cohen MD

SIGNED DATE 11/5/06

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)

FREDRIC COHEN MD
61 EAST 66 ST
NEW YORK NY 10021

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

FREDRIC COHEN MD
(212) 452-0077 61 EAST 66 ST
NEW YORK NY 10021

PIN# GRP#

PATIENT AND INSURED INFORMATION — CARRIER — PHYSICIAN OR SUPPLIER INFORMATION

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE (8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM HHG-1500, APPROVED OMB-0915-0028 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER — (ID)
1a. INSURED'S I.D. NUMBER: W058679960 (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ZELDIN TATYANA
3. PATIENT'S BIRTH DATE: 10/24/1961 SEX: F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ZELDIN TATYANA

5. PATIENT'S ADDRESS (No., Street): 49 COMMODORE DR.
6. PATIENT RELATIONSHIP TO INSURED: Self
7. INSURED'S ADDRESS (No., Street): 49 COMMODORE DR

CITY: STATEN ISLAND | STATE: NY
8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student
CITY: STATEN ISLAND | STATE: NY

ZIP CODE: 10309 | TELEPHONE (Include Area Code): (718)277-6261
ZIP CODE: 10309 | TELEPHONE (INCLUDE AREA CODE): (718)277-6261

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 800201-10-100

a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES | NO
a. INSURED'S DATE OF BIRTH: 10/24/1961 SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY SEX: M | F
b. AUTO ACCIDENT? PLACE (State): YES | NO
b. EMPLOYER'S NAME OR SCHOOL NAME: AUTOMATIC DATA PROCESSING INC.

c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES | NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA

d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO (If yes, return to and complete item 9 a-d.)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED
DATE
12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO

19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 478.1
2. 478.0
3. 470
4.
22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER: 38398061

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
04/12/2005	04/12/2005	11	S	31237		478.1	5000.00					
04/12/2005	04/12/2005	11	S	31238		470	2500.00					
04/12/2005	04/12/2005	11	S	30310		478.0	2500.00					
04/12/2005	04/12/2005	11	S	30560			2500.00					
04/12/2005	04/12/2005	11	S	99070			1500.00					

25. FEDERAL TAX I.D. NUMBER: 112-49-5859 SSN EIN
26. PATIENT'S ACCOUNT NO.: ZEL
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO
28. TOTAL CHARGE: $ 14000.00
29. AMOUNT PAID: $ 0.00
30. BALANCE DUE: $ 14000.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
PREDRIC J COHEN
61 EAST 66 ST
NEW YORK NY 10021

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
PREDRIC J COHEN
61 EAST 66 STREET (212)452-0077
NEWYORK NY 10021
PIN# GRP#

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM HCFA-1500 APPROVED OMB-0720-0035 FORM DWCP-1500, APPROVED OMB-0730-0008 (CHAMPUS)

STATE OF NEW YORK)
COUNTY OF NEW YORK) ss.:

I, Catherine Lella, being duly sworn, say: I am not a party to the action, am over 18 years of age and reside in Suffolk County, New York.

On October 27, 2006, I served a copy of the within summons and endorsed complaint by depositing a true copy thereof, in a post-paid wrapper under the exclusive care and custody of the U.S. Postal Service within New York State, addressed to each of the following persons at the last known address set forth after each name:

Aetna U.S. Healthcare Insurance Company
99 Park Avenue
New York, New York 10016

Catherine Lella
Catherine Lella

Sworn to this 27th day
of October, 2006

Notary Public

ROBERT A. SANTUCCI
NOTARY PUBLIC, ST. of N.Y.
#02SA4671860
COMMISSION EXP[illegible] 31, 20[illegible]

(3)

mbr = Yahaira Kosten